Mr. Chairman and Members of the Health Subcommittee:

My name is Alan Pierrot. I am an orthopedic surgeon from Fresno, CA and a founding member of the Fresno Surgery Center, a multispecialty physician owned surgical hospital. I am here today on behalf of the American Surgical Hospital Association (ASHA), the national trade organization representing 75 physician owned hospitals that specialize in surgical care, the vast majority of such hospitals in the United States. I served as the first president of ASHA and continue to be active on the board of directors. I appreciate the chance to represent our patients, our staff, our doctors and our facilities.

THE VALUE OF SPECIALTY HOSPITALS

The Fresno Surgery Center opened as an ambulatory surgery center in 1984, largely in response to the problem surgeons were having with operating room schedules and the efficiency at the local hospitals. Four years later we added a 20-bed inpatient care unit under a pilot project authorized by the California legislature. In 1993 we converted that unit to a licensed hospital. We promised the legislature that we could improve surgical care and patient satisfaction and we did. Physicians in other communities have now adopted this structure as a response to their frustration with general hospital operations. Our hospital is licensed by the state of California as an acute care facility, just like all the general hospitals in the state. This is the case in other states as well.

The Fresno Surgery Center and the other members of ASHA provide cost effective, high quality surgical care in a very efficient manner. Specialty hospitals offer a choice of surgical site both for patients and physicians. Our patients are very satisfied with the care they receive, and far prefer the model we offer to that provided in the typical general hospital. We get high marks from our patients, our staff and our physicians, whether or not they are investors. Surveys of patients indicate there are five conditions they would like in a hospital experience: a private room, good food, a welcome environment for visitors, a nurse that responds promptly and control over sound, heat and light. The typical American hospital provides not one of those conditions to its patients, its

customers. There is probably no industry less responsive to customers than the hospital industry.

I particularly want to emphasize the excellent patient outcomes we achieve. In Fresno our nurse to patient ratio is about 1:3.5 and it is well established that the nurse-patient ratio is a prime determinant of quality of care and medical outcome. In California hospitals generally the ratio is about 1:8 and the state had mandated a standard of one nurse for every six patients. That standard has been challenged by California general hospitals. On all measures of quality, surgical hospitals excel, including lower infection rates, few transfers to other hospitals, fewer medical errors and very low readmission rates.

ASHA believes that two factors are primarily responsible for this excellent record that is replicated across its membership. The first is physician ownership and control of the hospital's values and patient care standards. The second is the very fact of specialization that allows physicians and staff to develop proficiency in all facets of surgical care.

Physician investment in these facilities, whether alone or as part of a joint venture, is a key ingredient to our success. It means that the people whose names are on the door are responsible for setting the quality standards, the operational requirements and directing all facets of the hospital's activities. It is this group of investors who are fundamentally responsible for the existence of the hospital and the maintenance of its standards. They create the environment that is so attractive to patients and other physicians. One of my greatest points of pride about the specialty hospital concept is the number of surgeons who bring patients to the facility even though they have no investment interest. They know that their patients will be treated with skill and respect from the moment they enter until discharge.

Because these hospitals provide a focused set of surgical services, the staff is able to develop a high degree of skill in these specialized areas. This skill makes possible the efficiency of operation and the high quality of patient outcome. We succeed because we

are "focused factories" designed to provide elective surgical care to otherwise healthy patients. Cardiac hospitals may care for a different population, but their adoption of heart focused, best hospital practices under the guidance of their physician investors also allows them to provide an excellent level of care to patients with serious medical conditions.

The presence of a surgical hospital in a community is positive for patients and health plans. Competition forces general hospitals to improve their own services to patients and can lead to a reduction in overall costs, as health plans are able to negotiate for lower rates. In non-competitive environments, there is little incentive to improve services and cost effectiveness, whether to please patients or payers.

THE GOVERNMENT'S REVIEW OF SPECIALTY HOSPITALS DOES NOT SUPPORT A CONTINUATION OF THE MORATORIUM

For the past four years there has been a great deal of rhetoric about specialty hospitals, but little solid information. We now have reports from the Government Accountability Office (GAO), the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) that shed more light on the issues in the debate.

MedPAC has looked carefully at the fundamental issue raised by general hospitals at the beginning of this debate—are specialty hospitals harming general hospitals to the detriment of patients? The current moratorium was imposed because of concern that such harm was occurring and the desire of Congress to obtain information that would let it answer this basic question.

MedPAC's report on March 8 found that general hospitals have not been harmed. They have effectively responded to the competition posed by specialty hospitals and remained as profitable as their peers in communities where no specialty hospitals exist. This is certainly true in Fresno where the general hospitals have thrived since Fresno Surgery Center opened. I know this to be the case in other cities where specialty hospitals

operate. No proof of harm to general hospitals, risk to patients or abuse of the Medicare program because of excessive or unnecessary surgery has been found. Therefore, there is no justification to continue the moratorium beyond the legislated expiration date.

I want to make an important observation about the current moratorium. I think there is a widespread view that the 18-month moratorium is benign, allowing existing specialty hospitals to proceed unhindered, while only limiting new development. This leads to the conclusion that an extension of the moratorium as recommended by MedPAC would also not harm existing facilities. In fact the moratorium is not benign, but has hurt many well-established specialty hospitals. That is because it limits the expansion of facilities, the introduction of new services and the addition of new investors in response to changing needs and circumstances in our communities. Most of our members are located in areas experiencing rapid population growth, yet they have not been able to expand the number of beds or add new specialties to meet that increased patient demand. Our ability to serve our patients has been eroded. Another moratorium would only exacerbate this situation. There is no justification for extending the moratorium on a model of care that does not harm general hospitals and that provides superior care and patient satisfaction.

Under the moratorium, hospitals that were under development were permitted to seek review by CMS to determine if the moratorium would apply. CMS announced that it expected to complete these reviews within 60 days of submission. As far as I know, only a few decisions were made in that time frame. For everyone else, it has taken months, following numerous CMS requests for detailed information, to get an answer. I have been involved in the development of a surgical hospital in Thousand Oaks, CA. It took almost ten months for CMS to finally issue an opinion, even though that facility was nearly ready to open in November 2003 when the moratorium was imposed on this industry.

I know that some concern has been expressed that there would be a rush to open surgical hospitals as soon as the moratorium expires. This is not accurate. Right now there are only about forty hospitals that are close to opening and all are currently under review by

CMS to determine if they are exempt from the moratorium's restriction on referrals. To my knowledge, no corporate developer has any projects in the pipeline beyond those just mentioned. It is important to understand that it usually takes two years to launch a new surgical hospital, so physicians deciding in June 2005 that they would like to build a surgical hospital would most likely not see that become reality until 2007. The idea that hundreds of specialty hospitals will quickly open once the moratorium expires has no basis in fact.

While other hospitals have posted impressive financial gains recently, our part of the industry has been hamstrung by the moratorium which has caused harm to patients, staff, physicians and the hospitals. The harm to patients arises because they are denied the opportunity to have their elective surgery in a facility with extremely low post operative infection rates. The risk of infection at a general hospital is much higher, and post operative infections delay healing and are costly to treat.

ASHA also believes that none of the government findings would justify any change to the current law governing physician ownership of hospitals.

MedPAC's analysis of specialty hospitals did show that Medicare's inpatient hospital payment system needs substantial revision. ASHA agrees with their recommendations and urges action on them this year. We are pleased that CMS is evaluating these proposals as part of the recently published proposed rule on the inpatient payment system. If adopted these proposals would greatly reduce the need for hospitals to depend on cross subsidies to support necessary, but poorly reimbursed care. Federal healthcare dollars would be better targeted to the actual costs of providing medical and surgical services in the hospital.

ASHA also supports full disclosure of ownership, consistent with the ethical standards of the American Medical Association. I, for one, am proud of my hospital and my involvement in it. I have had no hesitation in telling my patients about my ownership. I

also have never hesitated to perform their surgery in another facility if they requested that I do so.

THE WHOLE HOSPITAL OWNERSHIP EXEMPTION IN STARK II

The Federation of American Hospitals has filed a petition calling on the Department of Health and Human Services to restrict the whole-hospital exemption in the Stark law to hospitals that "provide a full range of services customarily offered by general community-based hospitals." ASHA believes that no evidence exists that should cause Congress or the Department to modify the current hospital ownership exemption. Physician ownership of hospitals and other facilities is not new. Physicians who owned the facilities started many of today's finest medical clinics, like the Mayo Clinic, Cleveland Clinic and the Ochsner Clinic Foundation.

Certainly no evidence supporting limits on physician ownership of hospitals was found in the original studies that led to the establishment of the Stark laws. In testimony before the House Ways and Means Committee in 1991, the individuals who conducted the original Florida studies on physician ownership and referral arrangements concluded that, "Joint venture ownership arrangements have no apparent negative effects on hospital and nursing home services."

The American Hospital Association also encouraged Congress to incorporate flexibility in the law governing referral arrangements. In testimony before the Ways and Means Committee in 1989, AHA noted, "Oftentimes, joint ventures which are the subject of H.R. 939 are well intended to provide the highest quality, most accessible and most reasonably priced medical care to the community." AHA urged Congress to take a "more flexible or less proscriptive approach, allowing ventures consisting of referring physicians, if such ventures are for a legitimate business reason…"

In 1995, testifying before the same Committee, AHA stated that "First there needs to be careful examination of the effects of the self-referral law on the development of new, more efficient delivery systems, and elements of the law that prevent new systems from

evolving must be stricken or amended." AHA went on to call for an expansion of the physician hospital ownership provisions in the Stark II law. The language that allows physicians to have ownership of hospitals is not a "loophole" in the Stark law, but a carefully reasoned provision designed to maintain flexibility in the evolution of healthcare delivery systems.

Regarding the FAH petition, an examination of the variation in services provided by general hospitals across the country quickly shows that there are many differences among those facilities that might be considered "general community-based hospitals." CMS could devote considerable energy to solving this puzzle. Does the Federation include a heart program among the obligatory "full range of services"? Most hospitals don't have one. Is Ob-gyn a requirement? There is great variation among general hospitals in how, or even whether, they provide those services. Maybe it should be based on revenue sources, but there's a problem with that also. According to a number of hospital consultants, more than 60 percent of general hospital revenue comes from inpatient surgical services. Does that mean that most "general community-based hospitals" are, in fact, surgical hospitals?

MedPAC debated whether or not to include a recommendation on the whole hospital exemption but decided not to incorporate one in their report on specialty hospitals. Among the concerns expressed during discussion of this idea was the fact that no one could predict where elimination or modification of the exception might lead. For example, physicians have purchased rural hospitals in an effort to keep them open. Those acts of community concern could be outlawed if the exemption were to be amended or eliminated. The recent purchase of a Tenet hospital in California by the physicians who had a long-standing relationship with the hospital might not be allowed. The effort of African American physicians in Atlanta to purchase and reopen a hospital serving a low income community might be frustrated. It is obvious that there is no clear line that easily distinguishes physician ownership of one hospital versus another.

ASHA is concerned that CMS has announced in the inpatient payment proposed rule that it is considering whether or not specialty hospitals provide sufficient levels of inpatient care to be considered a hospital for Medicare purposes. Just as the FAH petition raised more questions than it answered, ASHA believes that this idea is equally perplexing. Where does this leave many small, rural hospitals? Will they meet the standard, whatever that is? What about some of the more traditional specialty hospitals like eye and ear hospitals, psychiatric facilities or women's hospitals? CMS does not bother to elucidate a standard, suggesting that it has no real idea how to proceed with this concept. I want to remind the Subcommittee that every ASHA member is licensed by their state as an acute care hospital and is also certified by Medicare. Is CMS now going to ignore the lawful actions of the state licensing authorities? Will every hospital's Medicare certification be questioned and now be subjected to some new federal test, yet to be defined? Is this the way this Subcommittee wants the federal government to honor the lawful acts of state agencies? Is this how Congress intends to encourage healthcare innovation, improved quality and increased cost effectiveness, by giving new protections to costly, inefficient facilities?

SPECIALIZED HOSPITALS IN THE UNITED STATES

Specialized hospitals are not a new phenomenon in medicine and have been in existence in this country for many years. There are many hospitals, both not-for-profit and for-profit, that provide a limited array of medical services. For example, psychiatric hospitals are very focused in the kinds of patients they treat. Often they will not admit a psychiatric patient with significant physical comorbidities because they do not have the medical services that patient requires. Such individuals are admitted to general hospitals with psychiatric units. However, I have yet to hear the general hospitals accuse their psychiatric colleagues of "cherry picking." Children's hospitals and women's hospitals have a long history in this country and their services are certainly focused on those appropriate to the populations they serve. Eye and ear hospitals are just one more example of the kinds of specialization that has developed in hospitals. Again, I am not aware that general hospitals have accused eye and ear hospitals of "skimming the cream". Cancer hospitals are also facilities with a focused mission. Clearly specialization is not

the issue driving the opponents of ASHA's members. Something else must be motivating their enmity.

Perhaps that enmity stems from the fact that today's physician owned specialty hospitals are not seeking out niche services of no interest to the general hospitals, but are competing directly with them across a number of valued service lines. In any other industry competition and the benefits it can bring to consumers is encouraged. Hospital services should be no different so that society can reap the benefits of innovation and cost effectiveness that accompanies competition. Yet our opponents ask Congress to protect them from that competition. ASHA urges you to resist their call for protection, since MedPAC found that general hospitals have responded effectively to the competition offered by ASHA members, even going so far as to make an effort to improve their own services to patients, physicians and hospital staff. I doubt if those enhancements would have occurred in the absence of effective competition.

A careful examination of general hospitals in this country would show that they vary widely in the types of services they offer, consistent with their facilities, staffing and the kinds of physicians present in the community. For example, few hospitals have burn units and most do not have heart programs. Level 1 trauma centers are not common. Rural hospitals routinely send complex medical and surgical cases to their larger colleagues. The less difficult cases stay behind. Yet no one is accusing rural hospitals or critical access facilities of "unfair competition" or "skimming the cream" or "cherry picking."

The reality is that every hospital tries to do those things for which it is best suited and whenever possible sends other cases to a better equipped facility. Such behavior is appropriate and in the best interests of patients. I am certain that the Members of this Subcommittee would be outraged if hospitals failed to ensure that patients were treated in the most suitable facility, whatever or wherever that might be.

As I noted, ASHA is the trade organization for specialty hospitals. We have 75 member facilities, and all have some degree of physician ownership. All specialize in surgical care. While our cardiovascular hospital members focus just on heart care, the typical ASHA member provides services in six surgical specialties. Urology, general surgery, orthopedics, gynecology, neurosurgery and ENT are commonly found in these facilities.

Our members are located in eighteen different states. GAO found that 28 states had at least one specialty hospital, but approximately two thirds were located in seven states. In MedPAC's sample, almost 60 percent were concentrated in four states. This concentration is primarily due to the presence of certificate of need (CON) laws governing hospital construction. Most specialty hospitals are in states that do not have hospital CON requirements. Since CON laws tend to protect existing facilities from new entrants into the market, it should come as no surprise that our members are usually found in states that do not have such barriers to market entry. It is worth noting that both the Department of Justice and the Federal Trade Commission have called for an end to CON because of its anticompetitive effects.

WHY PHYSICIANS ESTABLISH SPECIALTY HOSPITALS

It is important that the Subcommittee understand why physicians establish specialty hospitals. Those reasons will vary in each community, but the interest in a specialty hospital usually begins after physicians have failed to persuade the general hospitals at which they practice to make changes that will improve physician efficiency and patient care. For example, the Stanislaus Surgical Hospital in Modesto was established first as an ambulatory surgery center and later as a hospital by surgeons who could not get reasonable access to the operating rooms at the two other hospitals in town. These hospitals were profiting from their cardiovascular and neurosurgery services. Those cases had first call on the OR. Orthopedics, urology, ENT and other surgical disciplines took what was left, and even then were often bumped by trauma and other emergency cases. The result was that elective cases were delayed until 10:00 PM or later, to the great unhappiness of patients and surgeons alike. While no one disputes the need for hospitals to deal quickly and effectively with emergencies, many hospitals have figured

out ways to keep the rest of the surgical schedule moving along. However the Modesto hospitals apparently could not do that, so Stanislaus arose out of this unresolved conflict.

Fresno is a similar case. My colleagues and I believed that we could provide a better model for elective surgical care. We could not persuade the hospitals to go along with our ideas, so we built our own facility and have never regretted it. We continue to care for patients at the other hospitals in Fresno, as do our colleagues in Modesto. In fact, we require our physicians to maintain privileges at one of the other general hospitals in town. That means, of course, that we are all subject to the on call and other requirements of those hospitals. In California, like many states, insurance contracts are the dominant reason patients go to one hospital or another. Therefore, we all must have privileges at multiple facilities if we are to meet the medical and financial needs of our patients. There may be rare examples of physicians moving their entire caseload to a surgical hospital, but those are truly the exceptions to the general rule.

To me this is one of the most interesting facets of the national debate over physician owned specialty hospitals. States historically have determined what kinds of facilities can be licensed as hospitals and have established various regulatory standards in this regard. For example, not all states require hospitals to have emergency departments as a condition of licensure. That is the case with my home state of California. The federal government has respected this state role and has focused its attention on quality standards for facilities participating in federal health benefit programs, for example Medicare's conditions of participation. Yet now we are debating whether or not the federal government should usurp that state role and decide what does and does not constitute a hospital for purposes of federal health programs. ASHA would argue that absent evidence of Medicare or Medicaid fraud or grave risk to the public health, there is no need for the federal government to infringe on these state determinations

Using state law as an indicator of the will of those residents, the Subcommittee could easily conclude that an extension of the moratorium or the addition of any other restrictions on specialty hospitals would be unnecessary in CON states. In those states

that have abandoned CON, such restraints on competition and innovation would probably be unwelcome.

While physician ownership characterizes ASHA members, the nature of those arrangements varies widely. GAO found that about one third of their sample was independently owned by physicians; one third had corporate partners like MedCath or National Surgical Hospitals; and one third were joint ventures between physicians and local general hospitals. ASHA's own survey of its members found similar characteristics.

Clearly not all general hospitals are hostile to specialty hospitals or joint ventures with their physicians. For example, Baylor hospital in Dallas has a variety of joint ventures with physicians, including specialized hospitals and ambulatory surgery centers. Integris Health System in Oklahoma City has a joint venture with an ASHA member hospital specializing in orthopedic services. HCA partners with physicians in numerous ambulatory surgery centers and an orthopedic hospital in Texas. Avera McKennan in Sioux Falls, SD, has a joint venture with MedCath and the cardiovascular physicians who practice there. Incidentally, Avera McKennan is across the street from the Sioux Falls Surgery Center, a physician owned surgical hospital. Both facilities have grown and prospered, and the physicians practice at both hospitals. The Fresno Heart Hospital is a joint venture between our largest not for profit hospital and local physicians.

RESPONSES TO CRITICS OF PHYSICIAN OWNED SPECIALTY HOSPITALS

I would like to turn to the main criticisms of physician owned specialty hospitals and address them. In many respects these attacks mirror what not for profit hospitals used to say about for profit institutions. Ambulatory surgery centers came under similar attack from both the for profit and not for profit hospital sectors. Years later the sky has not fallen as predicted and most hospitals across the country are doing well.

Fundamentally the allegations are that specialty hospitals hurt general hospitals financially and engage in unfair competition because they have physician owners. There

are a number of arguments used to justify these criticisms. These are (1) ASHA members have a favorable payor mix and refuse to admit or otherwise limit the number of Medicare, Medicaid and charity cases; (2) they focus on the highest paying inpatient DRGs; (3) they only take the easier cases in those DRGs; (4) physician ownership is a conflict of interest and gives specialty hospitals an unfair competitive advantage in the market; and (5) physician ownership leads to increased, and unnecessary utilization of surgical services.

Let me start with the first fundamental accusation made by our opponents—specialty hospitals have hurt general hospitals. The facts do not support that allegation. No general hospital has closed because of competition from a specialty hospital. There is no evidence that general hospitals have eliminated a critical service, like the emergency department, because of competition from a surgical hospital. MedPAC concluded based on its review of 2002 data that the financial impact on general hospitals in the markets where physician-owned specialty hospitals are located has been limited and those hospitals have managed to demonstrate financial performance comparable to other hospitals. Fresno has a 16 year history with specialty hospitals and our experience confirms the MedPAC conclusions. All Fresno hospitals have expanded since the debut of Fresno Surgery Center.

Although MedPAC tries to caveat this conclusion by noting the "small number" of specialty hospitals in its sample, the reality is that they looked at 48 hospitals, more than 50 percent of the entire complement of physician owned specialized facilities. By any statistical measure that is a more than adequate sample upon which to base sound conclusions.

I know for a fact that in Fresno the specialty hospital model has had no negative financial impact on local hospitals. The same is true in nearby Modesto, which also has a specialty hospital. The other hospitals are either expanding or have plans to expand. Kaiser is building a new hospital in Modesto. In fact hospital construction nationwide totals in the billions of dollars, hardly a sign of an industry in financial distress. General hospitals

obviously have access to capital and are sufficiently sound financially that lenders continue to finance their projects.

GAO found that "financially, specialty hospitals tended to perform about as well as general hospitals did on their Medicare inpatient business in fiscal year 2001". According to GAO, specialty hospital Medicare inpatient margins averaged 9.4 percent, while general hospitals averaged 8.9 percent. This is not a significant difference in performance. The highest margins were reserved for the for-profit general hospitals, such as those operated by Tenet and HCA.

According to the Health Economics Consulting Group (HECG), "Based on a longitudinal study of general hospital profit margins in markets with and without specialty hospitals, we find that profit margins of general hospitals have not been affected by the entry of specialty hospitals. Consistent with economic theory, the models consistently showed that the most important predictor of general hospital profitability was the extent of competition from other *general* hospitals in the same market area…Contrary to the conjecture that entry by specialty hospitals erodes the overall operating profits of general hospitals, general hospitals residing in markets with at least one specialty hospital have higher profit margins than those that do not compete with specialty hospitals."

Let's look at the unfair competition argument next. Our accusers say that specialty hospitals engage in unfair competition because they have physician owners. That ignores the reality identified by GAO that "approximately 73 percent of physicians with admitting privileges to specialty hospitals were not investors in their hospitals." Clearly these physicians find something very attractive about the specialty hospital model, even without an investment interest. They have no motivation to engage in "unfair competition". Perhaps they are drawn to the high quality of hospital care, as evidenced by a nurse to patient ratio of one nurse for every 3.5 patients and an almost nonexistent infection rate. Possibly the ability to keep to a tight surgical schedule attracts them. Most surgeons see patients in their offices once they finish their surgery. If that schedule

is disrupted so are the lives of the patients waiting not so patiently for their surgeon to meet with them.

The percent of ownership is another important factor. According to GAO, "On average, individual physicians owned relatively small shares of their hospitals. At half the specialty hospitals with physician ownership, the average individual share was less than 2 percent; at the other half, it was greater than 2 percent." MedPAC reported the range of ownership to be from 1 to 5 percent. While the return on investment can vary among physician owned facilities, the modest ownership shares and the large number of physicians who are using the facilities, but who have no investment, suggest that financial gain is a secondary consideration for most physicians. In previous testimony the House Ways and Means Committee, CMS reported that it found virtually no difference in referral patterns between physicians who were investors in specialty hospitals and physicians who used those facilities, but had no investment. Ownership is not affecting the medical judgment of physicians.

One cannot look only at a single side of a competitive market. Congress needs to consider the tools that general hospitals have to compete against specialty hospitals. According to the December 2004 report on specialty hospitals of the American Medical Association's Board of Trustees, these include (1) revoking or limiting medical staff privileges to any physician who invests in a competitive facility; (2) hospital-owned managed care plans denying patients admission to competing specialty hospitals; (3) exclusive contracting with health plans to exclude specialty hospitals; (4) refusing to sign transfer agreements with specialty hospitals; (5) requiring primary care physicians employed by the hospital to refer patients to their facilities or to specialists closely affiliated with the hospital; (6) requiring subspecialists to utilize the hospital for all of their medical group's referrals; (7) limiting access to operating rooms for those physicians who invest in competing facilities; and (8) offering physicians guaranteed salaries to direct or manage clinical services and departments in the general hospital.

In addition, not-for-profit facilities have significant advantages because of their special tax status. Society has given not-for-profit hospitals special tax benefits in part to compensate them for the essential community services they offer. If they fail to hold up their end of the bargain, they should lose this special treatment. An analysis by Harvard professor Nancy Kane suggests that as many as 75 percent of not-for-profit hospitals receive more in tax relief than they provide in charity care.

Much has been made of the unfair burdens that weigh down general hospitals that are not shared by specialty hospitals. Often cited is the fact that specialty hospitals are less likely to have emergency departments. The burden of EMTALA is frequently raised. General hospitals often talk about the need to support burn units or other costly services and how competition from specialty hospitals affects their ability to do that.

State law determines whether or not a hospital is required to have an emergency department. Surgical hospitals that are in states requiring emergency facilities have them and they are thus subject to EMTALA. If they are not required, surgical hospitals that treat only elective cases are not likely to have an ER, since it is an unnecessary expense and not consistent with the model of care provided. Heart hospitals, on the other hand, almost always have emergency departments because of the nature of the diseases they treat.

To the extent that such disparities are widespread, the payment changes recommended by MedPAC would relieve them by moving Medicare dollars from high pay to low pay cases, evening out the differences. However, Congress needs to remember that most general hospitals do not have burn units, level 1 trauma centers or even heart programs. In fact, most hospitals must transfer burn patients or cardiac cases to another facility with the capacity to care for those individuals. No one challenges that practice as "cherry picking". It is widely regarded as appropriate medical practice because the facility is not designed to care for that particular individual or condition.

The situation at most surgical hospitals is no different. They are designed to provide elective surgery to otherwise healthy patients. Patients needing such surgery who have multiple comorbidities would not be good candidates for a surgical hospital. Good medical judgement requires that the patient be admitted into the appropriate facility. In 1987-1988 I served on the California committee that developed the regulations for recovery care centers. The primary charge of the committee was to develop standards that would assure patient safety by preventing the admission of higher acuity patients to those specialized facilities. We fulfilled our mandate and developed rules to prevent high acuity patients from being inappropriately admitted to recovery care centers. Yet today those same actions would be characterized as "skimming the cream".

Heart hospitals are different in that many of their cases will be emergent, so they are designed to accommodate them. Emergency departments and ICUs or CCUs are commonly part of these facilities. They are likely to offer a broader array of supporting medical services, consistent with the medical needs of their cardiovascular patients.

Payor mix has been another contested area, with accusations lodged that specialty hospitals don't take Medicare or Medicaid patients. This simply is not true. According to the HECG, the average specialty hospital earns 32.4 percent of its revenue from Medicare, 3.7 percent from Medicaid, 46.4 percent from commercial payors, 18.1 percent from other sources, and provides charity care equal to 2.1 percent of total revenue. Cardiac hospitals have even higher Medicare rates. In addition the average specialty hospital paid nearly $2 million in federal, state and local taxes.

According to MedPAC, there was wide variation in Medicaid admissions among hospitals, although on average the rate of Medicaid was lower in specialty facilities when compared to general hospitals. Several factors account for the difference. First, hospital location is a major determinant of the level of Medicaid and charity care. Second, because surgical hospitals tend to focus on elective surgeries and have fewer emergency admissions, they may not see the same level of Medicaid traffic as a general hospital with a busy emergency department, which often serves as the source of primary care for the

uninsured or those on Medicaid. Third, many states have moved to managed care in Medicaid and have limited Medicaid patients' access to certain facilities. If a hospital is not on the approved list, it will not see very many Medicaid patients, and those that do show up will have to be transferred to another hospital that is on the state's list. This is the case in Fresno, where nearly all Medicaid patients are directed to a single hospital.

The disparities in the distribution of Medicaid and uncompensated care were recognized at MedPAC when Chairman Hackbarth said on January 12 that "I think all of us would agree that right now the burden of providing care to Medicaid recipients or uncompensated care is not evenly distributed. That's an issue that long predates specialty hospitals and it's an issue that has very important implications for the system. And to say that stopping specialty hospitals is going to materially alter that problem, fix that problem, I don't think that's the case."

Specialty hospitals may indeed have a different payor mix than many general hospitals, but that does not mean that the general hospital is being harmed. Hospitals with higher levels of Medicare and Medicaid are eligible for DSH payments in compensation. If their Medicare caseload is more complex, another point of contention, then the outlier payments can offset the higher costs. In California, Medicare is one of the best payers for inpatient surgery. No hospital, whether specialty or general, limits Medicare admissions in California.

ASHA members do not discriminate based on a patient's insurance or ability to pay. While our payer mix may be different than some other hospitals, it is not because of efforts to select the best insured individuals. As someone who spent many years in medical practice, I can assure you that most physicians know very little about the insurance an individual patient may, or may not, have. ASHA has committed to the Chairman of the Energy and Commerce Committee that our members will not discriminate based on ability to pay, and we will work with Congress to make sure that reality is true for every hospital. I offer the same pledge to the Subcommittee today.

Specialty hospitals have been challenged on the basis that they select only the highest paying DRGs. While MedPAC has demonstrated that some of the DRGs are more profitable than others, many of the cases treated in specialty hospitals are not drawn from the "rich" DRG pool. In fact many surgical DRGs are no more or less profitable than other services. To the extent that this is an issue, however, the payment recommendations of MedPAC would correct any disparities between rich and poor DRGs.

Within DRGs, the case is made that surgical hospitals select the easiest cases, thus maximizing the profit that can be obtained in any DRG. There are some differences in patient acuity, but they are slight, and would be addressed by MedPAC's payment recommendations.

When GAO looked at this issue, its analysis revealed little real difference in acuity of admissions. For example, among admissions to surgical hospitals, two percent of the cases were in the highest acuity groups, while general hospitals had four percent of their admissions for the same surgery fall into the most severe classification. In other words, 98 percent of admissions to surgical hospitals were healthy and 96 percent of admissions for the same services to general hospitals were in equally good health.

In hospitals that specialized in orthopedic care, 95 percent of admissions were in the lesser acuity categories, while 92 percent of comparable admissions to general hospitals had the same severity classification. In heart hospitals GAO found only a five- percent difference in acuity between specialized facilities and general hospitals.

These are not large differences. The only conclusion one can draw is that patients having elective procedures are generally healthy, no matter what kind of hospital they are in. If there are differences in the profitability of specialty hospitals versus general hospitals, it must be for reasons other than patient selection.

Let me now turn to the allegation that physician ownership of surgical hospitals has generated additional surgical volume, some of it of dubious medical necessity. The facts do not support this accusation.

MedPAC has determined that specialty hospitals do not add to the volume of surgery. The Commission could not find evidence that the increase in service volume experienced in communities with specialty hospitals was higher than that found in areas that had no specialty hospitals.

I would like to conclude by examining the allegations that physician ownership of hospitals is a conflict of interest and gives specialty hospitals a competitive edge over the general hospitals in their communities. I would argue that there is no conflict of interest when a physician owns the facility in which he or she provides services to patients. That issue was thoroughly debated when Congress considered the Stark laws and Congress chose to allow physician ownership of hospitals, ambulatory surgery centers, lithotripsy facilities and a number of other sites where the physician provided the service in question. The AMA has also addressed the potential conflict of interest at length and concluded that no conflict exists in these circumstances. AMA also recommends additional safeguards to protect patients and some of those have been incorporated in various safe harbors developed by the Inspector General.

AMA also raises an issue that I believe the Subcommittee must explore if it is going to consider whether physician ownership creates a conflict of interest that should be addressed in federal legislation. That is the conundrum of hospital ownership of physician practices, their employment of physicians (particularly specialists), and the ownership of health insurance plans by hospital systems. If one is to argue that physician ownership of hospitals is a conflict of interest, then one is surely bound to agree that hospital ownership of physician practices or employment of physicians raises the same concerns. If one arrangement is outlawed, then all should be dealt with in the same way.

There is one other resource that I urge you to look at as you consider the issue of physician owned specialty hospitals, and that is the more than 20 years' experience that Medicare has with ambulatory surgery centers (ASCs). There are now about 4,000 Medicare certified ASCs in this country, providing millions of surgical services every year. Nearly every ASC has some physician owners. Yet in the history of Medicare's coverage of ASCs, there is virtually no evidence that physicians performed unnecessary services or engaged in behavior that placed patients at risk. Nor is there any evidence that an ASC forced a hospital to close or curtail essential community services. Medicare's ASC experience should be a strong predictor to Congress that physician owned specialty hospitals also pose no risk to Medicare, to patients or to general hospitals.

A great challenge to the Subcommittee and to Congress generally will be digging through the layers of rhetoric, spin and cant to get to the real facts. It amazes me that so much has been said or written, much of it wrong or false, about fewer than 100 hospitals that make up about one percent of Medicare inpatient payments. However, it will be worth the effort to get past the rhetoric and examine the facts because there is solid information available to you on many points in the debate. I hope you will rely on that data to make any decisions about legislation that might impact the future of specialty hospitals.

In summary, after thorough government study the allegations against specialty hospitals have not been proven. Therefore, ASHA urges the Subcommittee to allow the moratorium to expire as scheduled in June. The reforms to Medicare's inpatient payment system suggested by MedPAC would greatly benefit the Medicare program and should be adopted. However there is no evidence to justify putting specialty hospitals under another moratorium during the period these needed changes are implemented or imposing any other limit on physician ownership of hospitals. ASHA will also work with Congress to address any concerns about disclosure of ownership or alleged discrimination based on ability to pay.

Mr. Chairman, ASHA appreciates the opportunity to present this testimony, and I would be pleased to answer any questions the Members of the Subcommittee may have.